CANADIAN THESES ON MICROFICHE

THÈSES CANADIENNES SUR MICROFICHE

National Library of Canada
Collections Development Branch

Canadian Theses on
Microfiche Service

Ottawa, Canada
K1A 0N4

Bibliothèque nationale du Canada
Direction du développement des collections

Service des thèses canadiennes
sur microfiche

NOTICE

The quality of this microfiche is heavily dependent upon the quality of the original thesis submitted for microfilming. Every effort has been made to ensure the highest quality of reproduction possible.

If pages are missing, contact the university which granted the degree.

Some pages may have indistinct print especially if the original pages were typed with a poor typewriter ribbon or if the university sent us an inferior photocopy.

Previously copyrighted materials (journal articles, published tests, etc.) are not filmed.

Reproduction in full or in part of this film is governed by the Canadian Copyright Act, R.S.C. 1970, c. C-30. Please read the authorization forms which accompany this thesis.

AVIS

La qualité de cette microfiche dépend grandement de la qualité de la thèse soumise au microfilmage. Nous avons tout fait pour assurer une qualité supérieure de reproduction.

S'il manque des pages, veuillez communiquer avec l'université qui a conféré le grade.

La qualité d'impression de certaines pages peut laisser à désirer, surtout si les pages originales ont été dactylographiées à l'aide d'un ruban usé ou si l'université nous a fait parvenir une photocopie de qualité inférieure.

Les documents qui font déjà l'objet d'un droit d'auteur (articles de revue, examens publiés, etc.) ne sont pas microfilmés.

La reproduction, même partielle, de ce microfilm est soumise à la Loi canadienne sur le droit d'auteur, SRC 1970, c. C-30. Veuillez prendre connaissance des formules d'autorisation qui accompagnent cette thèse.

THIS DISSERTATION
HAS BEEN MICROFILMED
EXACTLY AS RECEIVED

LA THÈSE A ÉTÉ
MICROFILMÉE TELLE QUE
NOUS L'AVONS REÇUE

Canada

NL 339 (r. 85/08)

National Library of Canada | Bibliothèque nationale du Canada

Ottawa, Canada
K1A 0N4

TC –

ISBN 0-315-21300-0

(166)

CANADIAN THESES ON MICROFICHE SERVICE – SERVICE DES THÈSES CANADIENNES SUR MICROFICHE

PERMISION TO MICROFILM – AUTORISATION DE MICROFILMER

• Please print or type – Écrire en lettres moulées ou dactylographier

AUTHOR – AUTEUR

Full Name of Author – Nom complet de l'auteur

LYNDA GRIFFITHS

Date of Birth – Date de naissance	Canadian Citizen – Citoyen canadien
05/09/41	☑ Yes / Oui ☐ No / Non
Country of Birth – Lieu de naissance	**Permanent Address – Résidence fixe**
CANADA	6403 - 148 ST. EDM. ALTA. T6H 4J4

THESIS – THÈSE

Title of Thesis – Titre de la thèse

ATTRIBUTIONAL STYLE OF RECOVERING ALCOHOLICS

Degree for which thesis was presented Grade pour lequel cette thèse fut présentée	Year this degree conferred Année d'obtention de ce grade
M. ED.	1985
University – Université	**Name of Supervisor – Nom du directeur de thèse**
U. OF ALTA.	DR. E. E. FOX

AUTHORIZATION – AUTORISATION

Permission is hereby granted to the NATIONAL LIBRARY OF CANADA to **microfilm** this thesis and to **lend** or **sell copies of the film.**

The author reserves other publication rights, and neither the thesis nor extensive extracts from it may be printed or otherwise reproduced without the author's written permission.

L'autorisation est, par la présente, accordée à la BIBLIOTHÈQUE NATIONALE DU CANADA de **microfilmer** cette thèse et de **prêter** ou de **vendre des exemplaires du film.**

L'auteur se réserve les autres droits de publication; ni la thèse ni de longs extraits de celle-ci ne doivent être imprimés ou autrement reproduits sans l'autorisation écrite de l'auteur.

ATTACH FORM TO THESIS – VEUILLEZ JOINDRE CE FORMULAIRE À LA THÈSE

Signature	Date
Lyn Griffiths	Apr 22/85

NL-91 (r. 84/03)

Canada

THE UNIVERSITY OF ALBERTA

Attributional Styles of Recovering Alcohol Abusers

by

© Lyn M. Griffiths

A THESIS

SUBMITTED TO THE FACULTY OF GRADUATE STUDIES AND RESEARCH

IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE

OF M.Ed.

Department of Educational Psychology

EDMONTON, ALBERTA

Spring 1985

THE UNIVERSITY OF ALBERTA

RELEASE FORM

NAME OF AUTHOR Lyn M. Griffiths

TITLE OF THESIS Attributional Styles of Recovering Alcohol Abusers

DEGREE FOR WHICH THESIS WAS PRESENTED M.Ed.

YEAR THIS DEGREE GRANTED Spring 1985

Permission is hereby granted to THE UNIVERSITY OF ALBERTA LIBRARY to reproduce single copies of this thesis and to lend or sell such copies for private, scholarly or scientific research purposes only.

The author reserves other publication rights, and neither the thesis nor extensive extracts from it may be printed or otherwise reproduced without the author's written permission.

(SIGNED) Lyn Griffiths

PERMANENT ADDRESS:

6403 - 148 St.

Edmonton, Alta.

DATED April 22 19 85

THE UNIVERSITY OF ALBERTA

FACULTY OF GRADUATE STUDIES AND RESEARCH

The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research, for acceptance, a thesis entitled Attributional Styles of Recovering Alcohol Abusers submitted by Lyn M. Griffiths in partial fulfilment of the requirements for the degree of M.Ed..

E. E. Fox

Supervisor

Date Apr 22/85

Dedication

This is dedicated to Lillian May Smith

and to Lillian Lea Hamer.

The former gave me life,

the latter taught me reverence for it.

Abstract

An investigation was made of the attributional styles of recovering alcohol abusers as they related to personal characteristics of an Alcoholics Anonymous (AA) group. The variables representing personal characteristics were derived from a multiple determinant approach to alcohol abuse, particularly the cognitive social learning model. In addition, the study involved an evaluation of the Attributional Style Questionnaire in regards to the capacity of the instrument to discriminate different attributional style profiles between an AA group and a non-AA group, and then the capacity to discriminate between both groups as contrasted to a norming population.

A Personal Data Questionnaire was used to obtain personal characteristics of the 58 AA subjects and the Attributional Style Questionnaire was used to access attributional-style profiles of the AA group and the 35 subjects of the non-AA group. AA subjects were recruited from various AA centers in Calgary and Edmonton. Non-AA subjects were recruited from various occupational settings in Edmonton.

Characteristics of the sample were described by catagories and by correlations with attributional style scores. The first hypothesis investigated differentiation of attributional styles between groups.

Hotelling T^2 tests were used in the analysis on the differences of the multiple dimensions of the ASQ, between the AA and non-AA groups, then both groups in contrast to the normed population which was significant at .05. That is, the data supporting differentiation between the groups revealed that recovering alcohol abusers tend to be more internal, stable and global in inferring causality for negative events, and more external, variable and global in inferring causality for good events, in comparison to both a non-alcohol abusing sample and a norming population.

The subsequent hypotheses concerned characteristics of parental drinking patterns, negative events experienced prior to problem drinking, depression experienced prior to problem drinking, and gender, as correlates of attributional styles for negative events. Although

correlations did not support the predicted relationships to the attribution style scores for negative events, conditional exceptions emerged, for single dimensions and included such factors as father's drinking level, length of time in AA, level of attraction to AA, and level of responsibility for changes.

The results were discussed in terms of the multiple determinant approach to alcohol abuse, which included the cognitive social learning model of alcohol abuse (Marlatte & Donovan, 1982) and the reformulated helplessness model (Abramson, Seligman, & Teasdale, 1978).

Acknowledgments

I would like to thank my thesis supervisor, Dr. Eugene E. Fox for his support and assistance in the preparation of my thesis. I would like to thank Dr. Dustin T. Shannon-Brady and Dr. Lesley Hayduk for serving as my committee members.

I would also like to thank Deborah Caine, Kathleen Cooke, and Leith DeTracey, for their assistance and encouragement, and as well, Judith Abbott and Denise Gramlich for their assistance in typing the thesis.

Finally, I would like to thank my husband, Frank Griffiths, for the many, many years of his support.

List of Tables

Table	Description	Page
1 (Part 1)	Attributional Style Mean Scores for Each Group	21
1 (Part 2)	Hotelling T^2 - Tests as Dependent Samples Between Groups	22
2	Correlations of Father's Drinking Level and Mother's Drinking Level, with Mean Scores for Bad Events	24
3	Correlations of Length of Time in AA with Mean Scores for Bad Events	24
4	Correlations by Sex of Length of Time in AA with Mean Scores for Bad Events	25
5	Correlations of Previous Loss Experience with Mean Scores for Bad Events	27
6	Correlations of Previous Depression Experience with Mean Scores for Bad Events	27
7	Correlations of Sex with Mean Scores for Bad Events	27
8	Characteristics of the AA Study Population	28
9	Characteristics of the Non-AA Group Compared with the AA Group	34
10	Significant Correlations of Characteristics of the AA Group with Attributional Style Scores	35

Table of Contents

Chapter	Page
I. INTRODUCTION	1
II. LITERATURE REVIEW	3
A. The Disease Model of Alcoholism	3
B. The Cognitive Social Learning Model of Alcohol Abuse	5
C. The Reformulated Theory of Learned Helplessness	6
III. PROCEDURE AND METHOD	11
A. Procedure	11
B. Sample	11
C. Tests and Measures	12
D. Analysis	12
IV. THE ALCOHOLICS ANONYMOUS PERSPECTIVE	13
A. Overview	13
B. Historical Background	13
C. AA As A Treatment System	14
D. Treatment Strategies	17
E. Treatment Effectiveness	18
F. Summary	18
V. RESULTS	20
A. Hypotheses tested for significance	20
B. Subject characteristics	26
C. Characteristics of AA versus Non-AA Groups	33
D. Characteristics of the AA Group Associated With Attributional Style Scores	33
E. Summary	37
VI. DISCUSSION	38
A. Major Findings	38

B. Limitations 42

C. Directions for Further Research 43

VII. REFERENCES 44

VIII. APPENDIX A 48

IX. APPENDIX B 54

X. APPENDIX C 61

I. INTRODUCTION

Trends in Alberta toward increasing consumption of alcohol, together with corresponding increasing alcohol abuse indicate that further research into the field is warranted (Digman, 1982). Although the Alberta Alcohol and Drug Abuse Commission (AADAC) had developed educational programs to enhance prevention, and maintains rehabilitation facilities, there exists no formal or comprehensive training programs for professional health care workers, in the substance abuse field (O'Brien & Chafetz, 1982). Moreover, AADAC does not currently provide systematic individual assessment, nor does AADAC attempt to match the treatment to the individual.

Alcoholism or alcohol abuse, does not have a single cause (Schuckitt & Haglund, 1982); it effects all age groups and cuts across all strata of society (Davison & Neale, 1978); and it effects men and women differently (Hennecke & Fox, 1980; Saunders, 1980; Gomberg, 1982; Johnson, 1982; Tucker, 1982). Historically, the most stable theoretical perspective of alcohol abuse has been the concept of the disease model, which implies unitary causality and may foster passivity and irresponsibility in the individual (O'Brien & Chafetz, 1982). However, current trends in the literature suggest that a multiple determinant approach may facilitate an understanding of the complex nature of alcohol abuse, which in turn can lead to better assessment techniques, and a more efficient and effective treatment for the individual (Kissin & Hanson, 1982; Moos & Finney, 1983; Wanberg & Horn, 1983). Kissin and Hanson (1982) suggest that alcohol consumption patterns are influenced by the interaction of: social support and/or stress; psychological resources or perceived inability to cope with stress; and the physiological discomfort of withdrawal symptoms. In supporting the multiple determinant approach, Wanberg and Horn (1983) indicate that past background, current life situation, self-confidence, and perceived anxiety-depression, represent some of the variables which should be considered in evaluating problem drinking. In addition, Moos and Finney (1983) indicate that life-context factors such as: family or social support, job satisfaction, negative life events and depression, are elements which impinge on treatment success. Furthermore,

Moos and Finney (1983) suggest that the role of life-context factors should be evaluated as interacting variables during the process of treatment.

Following along this line, in that what happens outside of therapy will influence what happens inside therapy, what a person thinks or says to the self about the consequences of interacting with the environment, can enhance or inhibit change. This process of thinking or self-talk, produces two kinds of cognitive products: attributions, which are beliefs about the causes of past actions or events; and expectations which are beliefs about potential outcomes of future actions or events (Hollon & Kriss, 1984). McGovern (1983) indicates that "attributions", which he defines in the treatment context, as perception of the self as causal agent in producing changes during treatment, and "expectancies", which he defines as perception of the self as having the chance or choice to produce enduring changes and responsible behavior in the long run, are central to treatment progress. Furthermore, Peterson and Seligman (1984) indicate that individuals tend to project a characteristically consistent, "attributional style", which can be interpreted as a dependent variable, influenced or modified by life-events. Accordingly, since attributions may reflect an important element in the recovery process, this study will use the Attributional Style Questionnaire (ASQ) (Peterson, Semmel, von Baeyer, Abramson, Metalsky, & Seligman, 1982) to measure individual differences in attributional styles, amongst recovering alcohol-abusing individuals, currently attending Alcoholics Anonymous (AA) meetings, in various Alberta centers. A Personal Data Questionnaire (PDQ) will be used to assess the relationship of antecedent life-context factors to alcohol abuse.

II. LITERATURE REVIEW

In order to cast the current study into perspective, it would appear advantageous to review pertinent background information. In particular, the disease model of alcoholism is presented, not only because it is the first model of alcohol abuse, which shifted focus from moral weakness, to a medically-treatable illness, but also because it is fairly pervasive amongst health care workers and clients, and reflects implicit causality within the AA treatment system. Essentially, the disease model is presented to demonstrate problems inherent in this simplistic view, and to display the need for a multiple-determinant model of alcohol abuse.

Next, the cognitive social learning model of alcohol abuse is presented, which displays the significance of learning experiences in association with cognitions, and behavioral inclinations, in the acquisition and maintenance of alcohol consumption patterns. Essentially, the cognitive social learning model is seen as an improvement over the disease model, in that it moves beyond the simplistic labeling of alcoholic versus non-alcoholic, and seeks to tap antecedent variables as they impinge on an individual's current cognitions and behavioral inclinations.

Finally, the reformulated theory of learned helplessness is presented as background information because of the intention of using attributional style, as a dependent variable. That is, it will aid in measuring individual differences in perceived causality, particularly for negative events. Research hypotheses are generated throughout and re-presented in concluding the literature review.

A. The Disease Model of Alcoholism

The disease model of alcoholism is the original model of alcohol abuse, which was accepted in the 19th century by the medical community, shifting the focus from moral weakness, implicating punitive measures, to a disease concept, implicating medical attention and treatment (O'Brien & Chafetz, 1982). The model assumes alcoholism is a progressive illness, with symptoms which include loss of control over drinking, but the disease can be held

in remission by abstinence (Westermeyer, 1976). Loss of control over drinking is associated with physiopathological changes by cell adaptation and increased tissue tolerance for the drug (Heather & Robertson, 1981). Although medicine has not identified the particular biological link in genetic predisposition to alcohol abuse, research continues for the underlying causative agent, assuming early-identification and chemical control as future treatment potential (Blum, Briggs, & Verebey, 1982). Genetic predisposition appears to be a more viable concept amongst male alcohol abusers, than their female counterparts, reflected in studies of twins, raised apart from alcohol abusing, biological parents (Goodwin, 1973; Goodwin, 1977). Interestingly, Gomberg (1982) in reviewing the twin studies, points out that amongst alcohol abusing women, the dysfunctional ways of coping with stresses and social pressure commonly found in precipitating and maintaining alcohol abuse, appears to play a more major role than any genetic factors.

In summary, various researchers have criticized the disease model for the unitary concept inherent in the model (Wanberg & Horn, 1983). Additionally, the criteria for effectiveness in treatment intervention has been narrowly defined as total abstinence rather than reduced drinking patterns or improvement in social or occupational spheres (Heather & Robertson, 1981). Marsh (1982) criticizes the model for promoting a passive, dependent role, particularly amongst women. Essentially, the disease model lacks the sophistication to deal with interaction of multiple variables (Wanberg & Horn, 1983; Kissin & Hanson, 1982), and tends to influence commitment to continuation and completion of treatment, by fostering attributions and expectancies that infer external responsibilities for "cure" (McGovern, 1983).

Overall, the disease model of alcoholism has been criticized for neglecting to consider the complexities involved in this problem in living (Wanberg & Horn, 1983). The cognitive social learning model is presented next as an alternative to the disease model of alcoholism, and reflects more of the social learning complexities involved, mediated by individual's cognitions. The significance of life-context factors in association with an individual's cognitions, proposed by the cognitive social learning model, play a major role in recovery process and are central

concepts in the current study. It would thus be appropriate to predict that different attributional style profiles will be evident for recovering alcohol abusers versus the attributional style profiles of a normal sample.

B. The Cognitive Social Learning Model of Alcohol Abuse

Within the cognitive social learning model of alcohol abuse, past learning and experience of the individual influence beliefs and expectations in the behavioral inclination of the individual toward alcohol use (Marlatte & Donovan, 1982). Alcohol abuse is understood to be a multiple-determined disorder. Early learning experiences acquired through exposure to the modeling behavior of parents and peers tends to influence drinking behavior (Nathan, 1983) and may also represent the origin of the expectations of the reinforcing properties of alcohol (Marlatte & Donovan, 1982). Individuals use alcohol to reduce tension, minimize negative affect states, and enhance social interaction (Donovan & Marlatte, 1980). Marlatte and Donovan (1982) indicate that perceived lack of control in a social situation and lack of appropriate coping skills tends to increase the need to rely on alcohol, which in turn leads to perceived lowered levels of self-efficacy and failure to exert control in future, stressful situations. In attributing lack of control to personal inadequacies, the individual tends to experience stress, dysphoria, a sense of helplessness and ultimately, a sense of lowered self-esteem (Abramson, Seligman, & Teasdale, 1978).

The cognitive social learning model proposes that excessive drinking will be associated with the following three factors; (1) perceived helplessness; (2) availability of alternative, adequate coping responses; and (3) expectations about the effects of alcohol (Marlatte & Donovan, 1982). Intervention includes acquiring new skills as alternative coping responses, and developing higher levels of self-esteem through positive, self-efficacy-enhancement experiences.

Accordingly, since treatment intervention implies individualized focus and feedback on progress, systematic individualized assessments are essential. Assessment of individual cognitive

style in the present study will be accomplished by administering the ASQ (Attributional Style Questionnaire).

In retrospect then, since early learning experience influences drinking behavior, it is reasonable to suspect that certain patterns of rearing would correlate to various attributional styles. That is, patterns involving parents who drink heavily may tend to be associated with a more helpless attributional style, amongst currently recovering alcohol abusers. Specifically, individuals with a family history of drinking problems, may tend to have a more internal, stable, global attributional style for bad events.

It is also reasonable to suspect that intervention, through the AA treatment system may include acquisition of new coping responses and development of higher levels of self-esteem, and would appear likely that individuals with a shorter length of association with AA, will tend to have a more internal, stable, global attributional style for bad events.

C. The Reformulated Theory of Learned Helplessness

One attributional style of thinking is termed learned helplessness, in the literature. The theory evolved from two areas. The first area involves an animal learning model of helplessness: dogs learned that termination of a shock was not contingent on their behavior and would not attempt avoidance although escape was available. This was translated into cognitive terms as expectations of future response-outcome. Simply restated, that means that it does not matter which response an organism gives as it will not influence the outcome. In human terms, learned helplessness served as a model to account for human depression and the failure to cope. That is, the basic condition of helplessness, stemming from frequent or continual experience with lack of contingency between action and outcome, produces a belief that a person is helpless to deal with the environment, which results in depression (Seligman, 1975). The second area, involves attributional theory, which has evolved through various research areas. Briefly, attributions are inferences which people formulate regarding their own nature or that of others and the causes of important actions and events in their lives (Harvey & Galvin, 1984). The

significance in attributions is that they tend to influence future expectations, and the latter cognitive product is sufficient to produce symptoms of helplessness.

There were two major short-comings in the original helplessness model. First of all, the duration and intensity of the resultant depression could not be predicted, and additionally, a loss of self-esteem which always followed the feeling of helplessness went unexplained (Peterson & Seligman, 1984). To address these problems, Abramson, Seligman, and Teasdale (1978) reformulated the helplessness model. They now include the causal attributions of the individual in explaining the original uncontrollable events. Furthermore, they viewed causality on three dimensions: internal/external; stable/unstable; and global/specific (Abramson et al., 1978). The roles of each causal dimension were then defined as producing the following effects:

Effect (1): Internality influences self-esteem. i.e., If a person attributes causality to an internal dimension he will lose self-esteem.

Example: An alcohol-abusing person thinks that the problems incurred in excessive drinking are the result of being weak-willed, rather than identifying the external agent, alcohol as being the source of the problem. This will result in lowered self-esteem.

Effect (2): Stability influences the chronicity of helplessness and depression. i.e., If a person attributes causality to a stable dimension, he will tend to be more helpless and depressed.

Example: When every attempt to stop drinking, results in failure, the individual tends to retard his motivation in attempts to quit in the future. He tends to feel helpless and hopeless.

Effect (3): Globality influences the pervasiveness of the deficits; specificity limits deficits. i.e., If a person attributes causality to a global dimension, meaning that he generalizes across many life situations, rather than restricting it to a specific set of events, he will tend to be more helpless and depressed.

Example: When an alcohol-abusing person thinks that inability to control drinking is reflective of an inability to control all other facets of his life, he will tend to be more helpless and depressed.

Peterson and Seligman (1984) proposed that when reality is ambiguous, an individual may impose and project habitual explanations or a consistent characteristic explanatory style. These very styles which encompass internal, stable, and global dimensions can be used to predict depression in individuals encountering "bad" (negative) life events.

Peterson, Semmel, von Baeyer, Abramson, Metalsky, and Seligman (1982) developed the Attributional Style Questionnaire, normed on a university undergraduate population, which has been used in various studies, and has received support, in predicting depressive symptomology (Peterson & Seligman, 1984). Furthermore, Peterson and Seligman (1984) have indicated that research exploring antecedents of attributional style may tend to contribute to the validity of this model. That is precisely the aim of the present investigator. What in fact, are some of the identifiable antecedents of specific styles may tend to give an individual a predisposition toward an alcohol consumption pattern?

Individuals abusing alcohol are characteristically known to experience depression (Carroll, 1982) and women more so than men (Beck, Steer, & Shaw, 1984). Studies reveal an estimate between 3% and 98% incidence of experienced depressive symptomology in alcoholism. Khantzian (1982) postulates a link between depression and alcoholism, especially amongst women. Longer periods of sobriety tend to alleviate depression amongst recovering alcohol abusers (Kurtines, Ball, & Wood, 1978). Saunders (1980) has suggested that the learned helplessness model may be particularly relevant in understanding alcohol problems in women. The argument being that women have been reinforced to accept a more passive coping stance in dealing with life events. It has already been suggested progress in treatment is influenced by internal, stable, and global attributional style, especially when encountering negative life events. Gomberg (1982) has indicated that women with alcohol abuse problems have less social support available to them, than their male counterparts. Social support by other women tends to be an

important factor influencing treatment progress, which is available within the AA treatment system. Beckman (1980) has indicated that AA tends to facilitate cognitive changes through attributing past drinking behavior to external forces, rather than to internal characteristics, which redirects blame, assuages guilt, and enables development of a positive self-image. This would appear to be consistent with Peterson and Seligman's (1984) contention that a shift away from an internal, stable, and global explanatory style for negative life events would represent a shift toward a more flexible cognitive set, enabling the individual to cope more constructively with life-event challenges.

For the purposes of this study, attributional style represents the dependent variable - a personal current style of explaining causality, particularly for negative events in life. It is proposed that various antecedents may be associated with personal attributional styles. It also was proposed that women in particular may have a more self-defeating, internal attributional style.

The preceding review gives rise to certain underlying questions. A summary of those questions follows. Thereafter, the questions reformulated as testable hypotheses are listed.

Questions

1. Will different attributional style profiles be evident for recovering alcohol abusers versus the attributional style profiles of a normal sample?
2. Does having a family that had drinking problems influence attributional style?
3. Does length of time in a treatment system influence attributional style?
4. Does exposure to negative life events influence attributional style?
5. Does experience with depression influence attributional style?
6. Does gender influence attributional style?

Hypotheses

1. The attributional style profiles of recovering alcohol abusers will differ significantly from the attributional style profiles of a normal sample, for negative life events.
2. Individuals with a family history of drinking problems, will have a more internal, stable, and global attributional style for negative events.
3. Individuals with shorter lengths of time in AA will have a more internal, stable, and global attributional style for negative events.
4. Individuals with previous experience with negative life events will have a more internal, stable, and global attributional style for negative events.
5. Individuals with depression experience, previous to drinking problems, will have a more internal, stable, and global attributional style for negative events.
6. Women more than men, will have a more internal, stable, and global attributional style for negative events.

III. PROCEDURE AND METHOD

A. Procedure

The Personal Data Questionnaire, Appendix A, and the Attributional Style Questionnaire, Appendix B, were administered to Alcoholics Anonymous members, as a group of volunteers, at the close of fourteen open meetings. The subjects were told that this research was an attempt to enlighten those who work with alcohol abusing individuals. Individuals were assured of confidentiality, and encouraged to complete questionnaires as soon as possible.

B. Sample

Subjects for this study were volunteers from two sources. The first group was formed from volunteers from various AA conventional meetings at several centers in Calgary and Edmonton. Permission to recruit volunteers was obtained from the Chairperson of the meeting, and the preposed study was presented at the close of the each meeting. Of 150 Personal Data Questionnaires, plus 150 Attributional Style Questionnaires, 67 were returned by mail, with 9 excluded due to incompletion.

The second group of non-AA subjects was composed of volunteers from various occupational groups in Edmonton, by asking for volunteers in various occupational settings in the city. Of 40 Attributional Style Questionnaires distributed, 40 were returned, with 4 late returns and one incompleted. Sex, age, and occupation were the only demographic variables collected for this group. The only stipulation to meet requirement as a subject was that the individual not be AA.

Statistics concerning the samples are presented in detail in Chapter 5, Results. Briefly, the AA group was composed of 35 men and 23 women, in ages ranging from 21 years to 51 years of age and over. The Non-AA group was composed of 17 women and 18 men, in ages ranging from 20 years to 51 years of age and over. Both groups were represented by various occupational levels from professional to homemaker/retired and are presented in detail in

Chapter 5, Results.

C. Tests and Measures

The demographic and life-context factors were collected via the Personal Data Questionnaire (Appendix A). The attributional style was collected via the Attributional Style Questionnaire (Peterson, Semmel, von Baeyer, Abramson, Metalsky, & Seligman, 1982) (Appendix B).

By means of the Personal Data Questionnaire, the following demographic information was collected: gender, marital status, birth order, where the individual grew up, age, education level, occupational catagory, and length of time in Alcoholics Anonymous. In addition, personal information was also collected concerning early life experience which included alcohol expectancies, and later life experience which included encounters with negative life events, depression, attempts to control drinking, and personal perception of change.

The ASQ (Peterson, et al., 1982) provides three causality-dimension rating scales. These three scales are associated with twelve hypothetical events, which are scored in the direction of increasing internality, stability, and globality. Composite styles are created for two catagories of events (i.e., good events versus bad events) and produced by summing the appropriate items and dividing the sum by the number of items in the composite (i.e., 18 items in each catagory). Peterson, et al. (1982) reported that the ASQ has considerable construct, criterion, and content validity, when compared with other indices of helplessness and/or depressive symptomology and indicated satisfactory test-retest reliability in composite scores for good events ($r = .70$) and for bad events ($r = .64$).

D. Analysis

Frequencies and Pearson Correlations were conducted as initial analysis of data. Hotelling T2 Test was conducted on means differences between the AA group, the non-AA group, and the population mean group. Criterion significance was set at .05.

IV. THE ALCOHOLICS ANONYMOUS PERSPECTIVE

A. Overview

For those already familiar with the philosophy and historical background of Alcoholics Anonymous, this chapter can be omitted without losing the essential context of this thesis.

The following represents a brief historical background, a description of Alcoholics Anonymous as a treatment system, an outline of implicit treatment strategies, a brief discussion of treatment effectiveness, and a summary.

B. Historical Background

June 5, 1985, marks the fiftieth birthday of Alcoholics Anonymous. Historically, AA evolved from the experiences of two men, Bill Wilson, and Dr. Robert H. Smith, who are commonly referred to as "Bill W." and "Dr. Bob".

Bill W. was born in America, during an era when most of society and those in the helping professions had essentially written off alcoholics as morally weak, hopeless derelicts. Bill W. had experienced the early unhappiness of a broken home, and as a young man had quickly discovered that alcohol relaxed him socially, and provided him with a sense of freedom. After his Army service, Bill W. went to work as a stockbroker on Wall Street, where he soon encountered tremendous problems with his excessive drinking. He tried repeatedly to quit, until he was introduced by a friend to a religious organization, called the Oxford Group. With this group, Bill became aware of some progressive ideas which personally appeared to be central concepts in achieving sobriety: taking stock in one's shortcomings; and believing in a Higher Power to guide one's thoughts and activities. As Bill W. sobered up for the last time, he experienced deep depression. His progressive-thinking medical doctor, Dr. R. Silkworth, explained to Bill W. that alcoholism appeared to be a disease affecting both the mind and body and that cure involves rehabilitation of both. As Bill gradually recovered, he experienced a conversion to his personal concept of a Higher Power, and from that somewhat mystical

experience, he discovered that the essential key in avoiding relapse, was clearly in continued interaction with other alcoholics.

On a business trip to Akron, Ohio, Bill W. met another alcoholic, Dr. Bob. Bill W. related his own story to Bob, relating his conceptualization of the disease aspect of this drinking disorder and stressing the importance of continued interaction with other alcoholics. Dr. Bob gained his sobriety on June 5, 1935, and together they began reaching out to other alcoholics, organizing meetings in many other areas of the country (AA, 1975). To date, AA membership approximates one million members, world wide.

C. AA As A Treatment System

AA is a treatment system, which provides a framework for resocialization and development of a new ideology of life (Pattison, 1979). Essentially, AA is a fellowship of men and women who meet regularly, in various groups, to recover and share in the recovery of other alcoholics.

Although AA focuses on the alcoholic and not on understanding the roots of alcoholism, AA acknowledges that the disorder is a progressive disease, which can be arrested by not drinking. Their concentration is in helping the individual to achieve and maintain sobriety (Alibrandi, 1982). AA offers hope to individuals who are willing to try AA's "Twelve Steps", which are suggestions of how to let go of former behavior patterns and how to live without alcohol. Alibrandi (1982) presents a summarization of these steps:

1. admission of alcoholism
2. personality analysis and catharsis
3. adjustment of personal relations
4. dependence upon some Higher Power
5. working with other alcoholics" (p. 984).

The Twelve Steps are more than a means to sobriety: they represent an on-going framework to provide the the individual with an active means of participating in a more

constructive lifestyle; the aim is for progress, not perfection (Kinney & Leaton, 1982). Unlike the medical profession's interpretation of sobriety, AA's interpretation recognizes that in addition to not drinking, the individual requires the freedom to say no (Kurtz, 1982). It implies choice, and the responsibility inherent in the consequences of choosing. Kurtz (1982) suggests that the freedom to say no is acquired through "honest acceptance of essential limitation" (p. 46). This implies that the alcoholic's belief in control and independence, needs to be challenged and replaced by an affirmation of powerlessness over alcohol. In other words, the self-character of an individual is not the source of his drinking problems. Alcohol is clearly defined here as the external agent responsible for causing havoc in the life-style of the individual. Not drinking eliminates the source of the problem. Recovery begins with admitting to the self (and to others) that one is powerless over alcohol. In AA, this represents the first step: "We admitted we were powerless over alcohol, that our lives had become unmanagable" (AA, 1975).

Although the first step is a powerful beginning in the recovery process in that the individual must honestly acknowledge an alcohol problem, this admission is simply just a beginning. A simplistic deduction follows that if one avoids alcohol, one's life will become managable. Kinney and Leaton (1982) proposed that it is precisely at this level of recovery, an individual can become "stuck" or fixed with the idea that they are powerless, and consequently focus only on the not-drinking, entrenching the self against potential self-growth and autonomy. In addition, Marlatte (1979) postulated that the labeling of the self as "alcoholic" tends to reinforce helplessness in the recovering individuals. Furthermore, Marlatte (1979) proposed that if any individual has a slip at this stage, without the benefit of a relapse training program, the individual may view the event in a negative-self-sense, by what Marlatte calls the "Abstinence Violation Effect" (AVE). The two components of this cognitive-affect reaction are guilt and helplessness, which ultimately presents considerable difficulty for the individual with a lowered level of self-esteem, in regaining abstinence (Marlatte, 1979). Since AA does not maintain records of either individual members or of relapse tendencies, Marlatte's (1979)

abstinence violation effect amongst AA members is difficult to refute. However, individuals progressing beyond the first step, are availed to the counsel of AA's wisdom.

In Living Sober (AA, 1975) AA does discuss the possibility of relapse:

> "Try to remember that alcoholism is an extremely serious human condition and that relapses are as possible in this ailment as in others. Recovery can still follow... if you want to get well, and remain willing to try new approaches" (p. 87).

AA emphasizes willingness throughout its program, which implies choice and responsibility. An individual does not will himself to become an alcoholic, and, at the same time, an individual can will himself to become well, if courage and wisdom are chosen (AA, 1975). In fact, AA presents a challenge to the individual in asserting that alcoholics do not lack either willpower or mental ingenuity:

> "We know for sure that alcoholics do have tremendous willpower. Consider the ways we could manage to get a drink in defiance of all visible possibilities. Merely to get up some mornings - with a rusting cast-iron stomach, all of your teeth wearing sweaters, and each hair electrified - takes the willpower many non-drinkers rarely dream of. Once you've gotten up with your head, on those certain mornings, the ability to carry it all through the day is further evidence of fabulous strength of will. Oh yes, real drinkers have 'real' willpower" (AA, p. 85).

Emery and Fox (1981) also mentioned this potential that AA defines as willpower which therapists tend to overlook, amongst alcohol abusing individuals:

> "The activities in which an alcoholic must engage to satisfy his or her drinking and the sacrifices and hardships he or she must endure to maintain his or her drinking demonstrate amazing strength, initiative, and perserverance" (p. 184).

Emery and Fox (1981) additionally proposed that the manipulative behavior often cited as being found amongst alcoholics should be viewed as "problem-solving ability", which merely needs to be channeled in a socially adaptive manner. Furthermore, alcoholics do not lack goal-orientation, they simply need to change their goals, and this is exactly what AA attempts

to do.

D. Treatment Strategies

Gellman's (1964) analysis of AA's therapeutic process found, in facilitating attitudinal change, that permissiveness, support, stimulation, verbalization, and reality testing were all involved. As well, Miller and Hester (1983) indicated that the entire program is complex, impacting upon the individual's life, by extending learning far beyond the meetings themselves. Burt (1975) also pointed out that vicarious learning, social reinforcement, and behavioral contracting are implicit techniques operating in the AA program. Miller (1978) further elaborated, indicating that social skills training tend to be included in the progression through the twelve steps, in addition to the social and therapeutic benefit of the experience of being a model, when helping others.

In understanding the essence of AA, Kurtz (1982) proposed that the AA belief system is essentially a philosophy of existentialism. Accepting this philosophy, the individual finds meaning in life, enabling that individual to accept limitations of existence, responsibility for the self, and thus to orient the self towards personally-valued, future goals in life.

Similarly, Beckman (1980) contended that AA facilitates cognitive changes, which eventually result in the individual's adoption of a new set of attributions regarding alcoholism, and that these attributions facilitate and support non-drinking behavior and behavioral change. Since AA encourages past drinking behavior to be attributed to external forces, rather than to personal characteristics, blame can be redirected and guilt assuaged, enabling the development of a positive self-image; correspondingly, the emphasis on present responsibility, to seek help when needed, leads to continuing non-drinking behavior (Beckman, 1980). Beckman (1980) contended that the process of change within AA implicitly uses consistency, consensus, and covariation information, which are in fact, cognitive techniques aimed at altering attitudes and ultimately values, within the individual.

E. Treatment Effectiveness

Although AA represents one of the most stable and widespread treatment systems, and each group utilizes similar references and meeting format, there have been very few evaluative studies or interpretable findings to generalize either about AA's treatment effectiveness or the attributes of AA members (Miller & Hester, 1983). One of the major problems for researchers is embedded in one of AA's major principals, "anonymity", which is emphasized and practiced amongst members. In reviewing the literature, Miller and Hester (1983) indicated that the results from uncontrolled studies suggest an abstinence rate after one year, of between 26% and 50%. Alford (1980) compared two groups: one following the AA criteria of no drinking, and the other group participating in light drinking. After 24 months, the AA criterion group met with a 49% success rate whereas the light drinkers showed a 56% success rate, suggesting that the AA system was less effective than the alternative system, which provided for training in light drinking. In combining AA with formal treatment, Hoffman, Harrison and Belille (1983) found a 73% success rate after six months, amongst those patients who had faithfully attended weekly meetings of AA. In addition, both of the previously-mentioned studies stated that their subjects tended to have a diversity of personal attributes, in that there was no consistent character-type found who tended to be more successful with AA. Alford (1980) contended that unfortunately, what is still unknown is why AA works for some, but not for others. In fact, a major criticism leveled at AA is that as a treatment system, it has a high drop-out rate, suggesting that their program is not viable for all potential clients (Patterson, 1979). The question is not does AA work, but rather, what attributes tend to interact most effectively with the AA system.

F. Summary

In summary, AA evolved from the personal experience of Bill Wilson and Dr. Robert H. Smith. It is a stable, widespread, no-cost, treatment system, which appears to have an average success rate amongst individuals who can accept AA's narrow goal, sobriety. Although

researchers have been somewhat constrained by the anonymity amongst AA's members, the literature does suggest that various forms of psychological treatment techniques are in fact utilized within this treatment system. Clearly, AA offers information, hope, and an active, social-oriented, practical program to those who are willing to admit loss of control over alcohol, and who are willing to abandon personal responsibility for control over drinking.

V. RESULTS

This chapter begins with presentation of hypotheses that were tested. Following which, characteristics of the AA group are presented.There is a statistical comparison by percentages and by sex. Then the AA group is compared to the Non-AA group in terms of attributional styles.

A. Hypotheses tested for significance

For ease of reader reference, hypotheses will be restated, followed by the findings reported and the conclusions which the findings support.

1. The attributional style profiles of recovering alcohol abusers will differ significantly from the attributional style profiles of a normal sample, for negative life events.

   The findings indicate that the attributional profiles of recovering alcohol abusers differ significantly from the attributional profiles of a normal sample, not only for negative life events, but for positive life events as well. The attributional style means for both groups were calculated and tested for significant differences between groups by means of a Hotelling T2 test first as dependent samples, then as independent samples, the outcome of which is presented in Table 1. A review of the results show that not only do composite scores for both negative and positive events differ significantly between groups, but also that the individual dimensions within the composite scores differ significantly between groups, $P=0.000$. This shows that both the AA group and the Non-AA group have significantly different mean scores, in comparison with each other and also in comparison with the University of Pennsylvania State group, on which the ASQ was normed. In addition, the results affirm support for the ASQ as an instrument which is capable of discriminating different attributional styles amongst different populations.

2. Individuals with a family history of drinking problems will have a more internal, stable and global attributional style for negative events.

   Table 2 shows that for the overall composite score, there are no significant correlations

TABLE 1

Attributional Style Mean Scores For Each Group

	AA Group (N=58)		Non-AA Group (N=35)		Population Norms (N=130)	
Score	Mean	(SD)	Mean	(SD)	Mean	(SD)
Good event Composite	5.074	(.648)	5.010	(.611)	5.25	(.62)
Good event Internality	4.770	(.714)	4.976	(.546)	5.26	(.79)
Good event Stability	4.937	(.892)	5.091	(.686)	5.36	(.68)
Good event Globality	5.502	(.894)	4.962	(.959)	5.11	(.80)
Bad event Composite	4.399	(1.070)	3.771	(.770)	4.12	(.64)
Bad event Internality	4.621	(1.183)	3.861	(1.019)	4.29	(.84)
Bad event Stability	4.178	(1.090)	3.909	(.706)	4.14	(.71)
Bad event Globality	4.399	(1.407)	3.542	(1.072)	3.87	(1.07)

TABLE 1 (Part 2)

Hotelling T^2 - Tests
As Dependent Samples Between Groups

Groups	T2	F	DF1	DF2	Probability
AA & Population Norms	1091.454	119.677	8	50	0.000
Non-AA & Population Norms	1585.862	157.420	8	27	0.000
AA & Non-AA	180.692	19.8127	8	50	0.000

supporting this hypothesis. Within the dimension of internality, however, the correlation of r=.32, P=0.007, indicates that as fathers' level of drinking increases, the tendency to internalize the cause for a bad event increases. It appears likely that the hypothesis may have been too stringent in the focus on the composite score, and in addition, the Personal Data Questionnaire lacked sufficient levels of measurement to provide overall support for this hypothesis.

3. Individuals with shorter lengths of time in AA will have more internal, stable, and global attributional style for negative events.

   Table 3 shows that there are no significant correlations supporting this hypothesis. In partialing time by sex, significant differences do emerge for women, as shown in Table 4. For the overall composite score, a correlation of r=.64 is significant, P=0.000. This indicates that the longer the length of time that women have been in AA, the less inclined they will be to accept the blame and experience helplessness and lowered levels of self-esteem, when bad events occur. Similarly, the r=.60, P=0.003, between the dimension of internality and time length, shows that the longer the length of AA time, the less inclined these women will be in identifying the self as causal agent for bad events. These women will tend instead, to carefully consider circumstances or other people as potential causal source. Finally, the r=.70, P=0.000, between length of time and globality, shows that the longer the AA time, the more inclined these women will be in seeing bad events as specific to the original events. In other words, these women will tend not to generalize the original negative event across all other areas of their lives.

4. Individuals with previous experience with negative life events will have more internal, stable and global attributional style for negative events.

   The results of Table 5 show that there are no significant correlations to support this hypothesis. The hypothesis narrowly focused on previous loss experienced prior to onset of drinking problems, excluding loss experienced after joining AA. For this reason and again, lack of differentiating levels of the antecedent variable, contributed to lack of support for

TABLE 2

Correlations of Father's Drinking Level
and Mother's Drinking Level,
with Mean Scores for Bad Events (N=58)

Drinking Level	Composite r	Internality r	Stability r	Globality r
Father's Level	.22 p.048	.32 p.007	-.001 p.496	.23 p.039
Mother's Level	.07 p.304	.06 p.321	.05 p.365	.07 p.304

TABLE 3

Correlations of Length of Time
In AA with Mean Scores for Bad Events (N=58)

	Composite r	Internality r	Stability r	Globality r
Length of time in AA	.12 p.195	.04 p.392	.14 p.475	.23 p.044

TABLE 4

Correlations by Sex, of Length of Time in AA with Mean Scores for Bad Events

	Composite r	Internality r	Stability r	Globality r
Length of Time in AA				
Female (N=23)	.64 p.001	.60 p.003	.35 p.103	.70 p.000
Male (N=35)	-.23 p.089	-.28 p.052	-.25 p.073	-.10 p.289

this hypothesis.

5. Individuals with depression experience previous to drinking problems will have a more internal, stable, and global attributional style for bad events.

   The results of Table 6 reveal that there are no significant correlations in support of this hypothesis. As previously mentioned, it would appear that the hypothesis was set too stringently, excluding the potential inherent in depression experienced after joining AA and as well, seems likely that the PDQ lacked the power to discriminate between various levels of depression experienced prior to the onset of drinking problems.

6. Women more than men will have a more internal, stable, and global attributional style for bad events.

   The results of Table 7 indicate that there are no significant correlations to support this hypothesis. As previously mentioned, however, if length of time in AA is controlled some significant relationships emerge for women, as described in hypothesis number 3.

B. Subject characteristics

Table 8 indicates the characteristics of the AA subjects, as shown as percentages, by sex and total sample, as obtained by the Personal Data Questionnaire. The sex composition of 60% males and 40% females appears to show a reliable male/female ratio, considering that AA is currently evolving toward a more equal representation amongst the members (O'Brien & Chafetz, 1982). The marital status of 35% married compared with 65% non-married reveals that approximately one third of this sample have an intact social support system, which may tend to enhance the recovery process (Moos & Finney, 1983). The birth order indicates that over one half of this sample were first-born children. This would appear to contradict the concept that more alcohol abusing individuals tend to be last-born children, experiencing neglect or parental-bond dilution (Zucker, 1976). The 70% represented by women as first-born children may reflect strong parental influence in a family's experience with alcohol (i.e., modeling) or alternately, may suggest coping behavior in dealing with stressful family situations (Gomberg,

TABLE 5

Correlations of Previous Loss Experience with Mean Scores for Bad Events (N=58)

	Composite r	Internality r	Stability r	Globality r
Previous Loss Experience	-.04 p.397	-.09 p.244	.12 p.190	-.09 p.242

TABLE 6

Correlations of Previous Depression Experience with Mean Scores for Bad Events (N=58)

	Composite r	Internality r	Stability r	Globality r
Previous Depression	.15 p.127	.13 p.173	.21 p.058	.08 p.281

TABLE 7

Correlations of Sex with Mean Scores for Bad Events (N=58)

	Composite r	Internality r	Stability r	Globality r
Sex	-.03 p.410	-.09 p.254	.07 p.291	-.05 p.352

TABLE 8

Characteristics of the AA Study Population

Characteristic	Male (N=35) %	Female (N=23) %	Total (N=58) %
Sex			
Male			60
Female			40
Marital Status			
Married	29	44	35
Widowed	3	9	5
Divorced	34	44	38
Single	34	3	22
Birth Order			
First Born	43	70	53
Later Born	57	30	47
Location of Growing Up			
Large City	54	61	57
Small City	23	17	21
Village or Town	14	22	17
Farm	9	0	5
Age Range			
51 Years & Over	23	22	22
41 - 50 Years	23	18	21
36 - 40 Years	23	27	24
31 - 35 Years	14	13	14
26 - 30 Years	14	7	12
21 - 25 Years	3	13	7
20 Years & Younger	0	0	0
Level of Education			
College &/or University	26	35	29
Grade 12 plus Technical Training	46	26	38
Grade 9 - 12	23	39	29
Up to Grade 8	5	0	4
Occupational Level			
Professional	40	30	36
Technical	9	4	7
Trades	29	4	19
Services	14	13	14
Office &/or Clerical	8	26	15

Homemaker/Retired	0	23	9
Time Range Associated with AA			
7 Years & Over	20	22	21
3 - 6 Years	49	30	41
1 - 2 Years	14	35	22
3 - 11 Months	9	13	10
2 Months and Less	8	0	5
Age Range at First Drink			
17 - 20 Years	14	30	21
11 - 16 Years	51	57	53
10 Years & Under	35	13	26
Who Introduced Drinking			
Parents	49	35	43
Friends	43	61	50
Self	9	4	7
Father's Drinking Level			
None	3	17	9
Little	23	13	19
Moderate	26	17	22
Heavy	48	53	50
Mother's Drinking Level			
None	26	13	20
Little	49	39	45
Moderate	11	31	19
Heavy	14	17	16
Sibling Problem Drinking			
None	71	74	72
Yes	29	26	28
Reason Family Drank			
Fun	43	30	40
Avoid Negative Affect States	57	70	60
Parental Examples of Life Skills			
Many Times	26	17	22
Sometimes	37	30	35
Hardly Ever	17	35	24
Not at all	20	18	19
Own Reason for Drinking			
Fun	35	17	28
Avoid Negative Affect States	65	83	72
Awareness of Drinking Style			
Different from others	23	22	22
Same as others	77	78	78

Awareness of Extent of Alcohol Problem			
Major problem	34	8	24
Part of many problems	43	57	48
No idea of problem	23	35	28
Attempt to Stop Drinking on Own			
Yes	80	78	79
No	20	22	21
Sought Assistance Through AADAC			
Yes	60	52	57
No	40	48	43
Attraction to AA			
One particular person	20	44	29
Other people in AA	34	35	35
The Twelve Steps	46	21	36
Previous Loss: Before onset of drinking problems			
No	49	30	41
Yes	51	70	59
Loss After Joining AA			
No	37	30	34
Yes	63	70	66
Previous Depression: Before onset of drinking problems			
No	43	22	34
Yes	57	78	66
Depression After Joining AA			
No	37	35	36
Yes	63	65	64
Level of Improvement			
Great Deal	49	43	47
Somewhat	43	44	43
Very little	8	9	9
None at all	0	4	1
Source Responsible for Life Changes			
Myself	31	39	35
Others & myself	63	52	59
Others	6	9	6

1982). The location of growing up revealed relative equality, in that 57% grew up in a large city, while 43% grew up in a smaller social environment. The age range shows that 68% fall above 35 years of age, which may reflect a sample bias or the fact that age and length of time in the AA treatment system are related, perhaps revealing a tendency to feel well enough to want to volunteer. Level of education indicates that only one third of this sample have Grade 12 education or less. This too may reflect a sample bias in that higher levels of education may predispose an individual to volunteer for a research study (Kerlinger, 1973). The occupational catagories reveal sex differences which are mirrored in the general population. The exception is the professional catagory in which 40% of the males and 30% of the females, indicate that professionals are heavily weighted in this sample.

In regards to length of time in AA, 62% have been associated with AA for 3 years or more. Only 15% have been associated with AA for less than one year, perhaps reflecting a sample bias for reasons outlined previously in discussing the age range. The age at first drink indicates that 35% of the males began drinking at age 10 years or younger. On the other hand, only 13% of the females fell within this very young age-level of drinking experience. The introduction to alcohol catagory reveals that 49% of the males, in comparison to 35% of the females, were introduced to alcohol by their parents. On the other hand, 61% of the females indicated that friends had introduced them to drinking, compared to 43% of the males. Both males and females, at 48% and 53% respectively, indicated that their father's drinking level was classified as heavy. Mother's drinking level, on the other hand, tends to be classified as heavy by only 14% of the males and 17% of the females. Sibling problem drinking was affirmed by 28% of the sample. The reason associated with the family experience of drinking, reveals that 57% of the males, compared with 70% of the females, tended to use alcohol to avoid negative affect states. Parental examples in problem solving and social skills, shows that 37% of the males compared to 53% of the females, perceived that their parents had provided little, or no positive examples. This suggests that one third to one half of this sample may have an impoverished background in the acquisition of coping skills or strategies, which could provide

an alternative to drinking, in the face of a stressful situation, and would appear to be consistent with Marlatte and Donovan's (1982) concept of coping skills, as an alternative to alcohol use.

As to their own reason for drinking, 65% of the males, versus 83% of the females indicate that they drank to avoid negative affect states. Only 22% of the sample was aware that their drinking style was any different than others who drank. On awareness of the extent of an alcohol problem, 34% of the males, compared to only 8% of the females, thought that alcohol was the major problem. Alternatively, excessive drinking was identified by 48% of the sample as being part of many problems, pervasive as a problem in living. In attempts to stop drinking on their own, 79% of the sample indicated that they had tried. In seeking assistance through AADAC, 60% of the males and 52% of the females indicated that they had done so. In indicating attraction to AA, 44% of the females versus 20% of the males, reveal an attraction by one particular person. This contrasts to 21% of the females versus 46% of the males, who were attracted to AA by the dogma defined by the Twelve Steps. In experiencing a loss, prior to onset of drinking problems, 51% of the males, compared with 70% of the females, indicate that they had experienced a negative life event. Since association with AA, 63% of the males and 70% of the females affirm a loss experience. Previous-experienced depression, prior to the onset of drinking problems, is indicated by 57% of the males, compared to 70% of the females. Since association with AA, depression is indicated as experienced by 63% of the males, and similarly, by 65% of the females. This appears to be consistent with Carroll's (1982) finding that individuals abusing alcohol tend to experience depression, and also with Beck, Steer, and Shaw's (1984) assertion that this pattern prevails particularly more so for women.

The level of improvement that is perceived by the the individual is shown as 47% for a great level of change, 43% for a somewhat less perception of improvement, and 10% for little, or no change at all. Finally, on the source responsible for life changes, 31% of the males and 39% of the females see themselves as causal agent. This compares sharply with 69% of the males and 61% of the females who see others as responsible for producing changes in their lives. In other words, two thirds of this sample infer that external sources are the cause of life changes,

currently occurring, within the individual's life-style. Whether or not this tendency is due to the fact that AA defines alcoholism as a disease, and therefore "cure" must accordingly be attributed to external sources, is not entirely clear, but the tendency does exist.

C. Characteristics of AA versus Non-AA Groups

Characteristics of the AA group were compared to characteristics of the non-AA group on three variables: sex, age, and occupational level. Table 9 shows that these two groups were relatively similar in the three characteristics compared. The 51% males to 49% females, appears to be a valid comparison to the AA sex ratio of 3 to 2, favoring males. The age range shows that 67% of the group were over 35 years of age, which corresponds with the AA sample. The occupational level shows a similar professional catagory of 31%, compared to 36% found in the AA group. The trades catagory at 31%, appears more heavily weighted than the AA group at 19%, and may reflect a sample bias within the non-AA group, who are all from the same city.

D. Characteristics of the AA Group Associated With Attributional Style Scores

The characteristics of the AA group were correlated to Attributional Style scores. Since the sample size is small (i.e., N=58), only correlations approximating r=.31 or greater, were considered as significant (Kerlinger, 1973, p. 200). In Table 10, the largest correlation for the good events catagory was between occupational category and the globality dimension score, at r=-.48.

The correlation indicates that the higher the occupational level, the greater the tendency to view good events as generalizing to situations beyond the original event. The next highest correlation of r=-.42, between improvement level and stability dimension, indicates that the higher the level of perceived improvement, the greater the tendency to view good events as being stable across time. Educational level and globality, correlate at r=-.33, indicating that the higher the level of education, the greater the tendency to view good events as generalizing to situations beyond the original event. Between occupational level and the composite score,

TABLE 9

Characteristics of the Non-AA Group
Compared with the AA Group

Characteristic	Non-AA Group (N=35) %	AA Group (N=58) %
Sex		
Male	51	60
Female	49	40
Age Range		
51 Years & over	23	22
41 - 50 Years	17	21
36 - 40 Years	6	24
31 - 35 Years	20	14
26 - 30 Years	23	12
21 - 25 Years	8	7
20 Years & younger	3	0
Occupational Level		
Professional	31	36
Technical	3	7
Trades	31	19
Services	12	14
Office &/or Clerical	17	15
Homemaker or Retired	6	9

TABLE 10

Significant Correlations of Characteristics of the AA Group with Attributional Style Scores (N=58)

Part 1 - Good Events Catagory

Characteristics	Composite r	Internality r	Stability r	Globality r
Educational Level		-.32 p .007		-.33 p .006
Occupational Level	-.33 p .006			-.48 p .000
After AA Loss		-.33 p .006		
Improvement Level	-.31 p .010	-.42 p .001		

Part 2 - Bad Events Category

Characteristics	Composite r	Internality r	Stability r	Globality r
Father's Drinking Level		.32 p .007		
After AA Depression			.31 p .010	
Attraction to AA	.37 p .002	.42 p .001		
Responsibility Source	.40 p .001	.33 p .006	.41	p .001

r=-.33 shows that the higher the occupational level, the greater the inclination toward accepting self-credit for good events. Similarly, r=-.33, between loss, after AA, and internality shows that the less experience with negative life events, such as loss, the greater the tendency to see the self as causal agent of good events. Educational level and internality, with r=-.32, also indicates that the greater the tendency to see the self as causal agent of good events is related to the higher the level of education. Finally, the composite score and improvement level correlated at r=-.31, shows that the higher the perceived level of improvement, the greater the tendency to accept self-credit for good events.

Within the bad events catagory, the r=.42, between attraction to AA and internality, indicates that attraction to AA for dogma, rather that attraction to other people, is related to identifying the self as causal agent for bad events. Responsibility and globality, with r=.41, shows that the tendency to see others as responsible for life changes is related to generalizing bad events beyond the original situation. Similarly, r=.40 between responsibility and the composite score indicate that the more a person sees others as responsible for changes in his life, the more he will be inclined to accept the blame for the occurrence of bad events. Attraction to AA and internality, with r=.37, shows that the more one is attracted to AA by dogma, the more one will internalize responsibility for bad events. The r=.32, between father's level of drinking and internality indicates that the heavier one's father drank, the more inclined one will be to see the self as causal agent for the occurrence of a bad event. Finally, the r=.31, between depression experienced after joining AA and globality, shows that those who experienced depression after joining AA, are more inclined to view bad event occurrence as generalizing beyond the original event, to other areas of one's life.

In brief, blaming the self for bad events is related to: heavy levels of drinking by the father, depression after AA, attraction to AA for dogma, and seeing others as responsible for changes in one's life. Accepting the credit for good events is related to higher educational and occupational levels, lack of a negative life event (after joining AA), and in higher levels of perceived improvement in one's life style.

E. Summary

Briefly summarizing, the first hypothesis proposing inequality in the mean scores on the ASQ between the AA group, non-AA group and the norming population proved correct. The remaining hypotheses were not significantly supported. Conditional situations were identified and explanations for lack of support were provided. Characteristics of the subjects were presented as percentages by sex, and the characteristics overall, indicate heterogeneity in the AA group. AA subjects compared to non-AA subjects appear similar in age, sex, and occupational levels. Characteristics of the AA group were correlated to scores of the ASQ and significant correlations, approximating $r = .31$ or greater were reported.

VI. DISCUSSION

A. Major Findings

The results of the present study show that the attributional styles of the Alcoholics Anonymous group differed significantly from both the non-AA group, and the University of Pennsylvania group, on which the Attributional Style Questionnaire was normed. In addition, the non-AA group also differed significantly from the college population.

Overall, this finding indicates that the AA group tends to employ a more helpless explanatory style than either the non-AA group or the University of Pennsylvania group, especially in conjunction with negative or "bad" events. The tendency of the AA group to appear more helpless is revealed in two ways. First of all, the AA group has a more internal, stable, and global style prevalent for negative events. In other words, the AA subjects are inclined to see the self as causal agent when negative events occur, and to infer that the situation is stable, and non-specific. In turn, this inclination may produce lowered levels of self-esteem. In the second place, the AA subjects are less inclined to take the credit, when good events occur. Alternatively, these people tend to view external sources, or circumstances, as responsible for the occurrence of good events, and similarly, do not see the situation as being stable. The AA subjects do perceive that good events effect more areas of their lives, in contrast to limiting the original event to the specific situation. Given that 57% of the men and 70% of the women indicated prior experience with depression, this finding does show a distinct tendency, and appears consistent with Peterson and Seligman's (1984) findings concerning the relationship between depression and attributional styles, even though the hypothesis directly relating to this relationship was not supported.

Interestingly, the non-AA group reflects a similar pattern to the AA group in regards to good events, with the exception of limiting the good event to the specific situation. In other words, the impact of a good event occurring was not perceived as effecting many areas of their lives, as was the case for the AA group. In addition, the non-AA group was much less inclined

to accept the blame for the occurrence of bad events. Instead, these subjects were more inclined to view circumstances and others as influencing the event, and correspondingly, saw the event as variable and non-specific. In other words, a self-serving pattern emerged in the non-AA group, of taking the credit for good events, but mediating the bad events by considering circumstances, and/or others, in inferring causality. Interestingly, this strong inclination amongst the non-AA subjects contrasted not only to the AA subjects, but also with the University of Pennsylvania population. It appears likely that age and life-style of a non-college, mature sample would tend to influence attributional styles, thereby revealing a self-serving pattern which appears to be a flexible, coping resource in the lives of healthy individuals. This finding also provides support for the Reformulated Helplessness model, and is consistent with Peterson and Seligman's (1984) observation that individuals in natural-event settings tended to cope with real-life stressors more effectively, when an attributional style which closely resembled the non-AA style, prevailed amongst the individuals. That is, a disinclination to infer the cause of bad events to one's own character, was indicated by these people. This in turn, would serve to preserve self-esteem, and to avoid feeling helpless and hopeless in the face of a natural-occurring bad event. In general, the differences between the groups indicate that the ASQ has ecological validity in discriminating different attributional styles for different populations.

The hypothesized attribute variables associated with attributional styles for bad events, were not supported by the results of this study. As previously mentioned in Chapter 5, it would appear likely that test items did not adequately discriminate sufficient levels of the variables in question, to provide an adequate measure for comparison with the ASQ scores. Some conditional tendencies did emerge and were discussed in detail in Chapter 5. Essentially, for women, the longer they are in AA, the less inclined they will be to accept the blame for bad events. It appears that AA works for women by providing a social support system, in addition to good role models to emulate. Other significant associations did emerge, correlating attributional styles with variables other than the hypothesized variables. These associations were

as follows: higher levels of education and occupational catagories, lack of a negative life event, longer lengths of time in AA, and higher levels of perceived self-improvement in one's life-style were related to a tendency to accept the credit for occurrences of good events; a tendency to accept the blame for the occurrence of bad events was related to heavy-levels of father's drinking, attraction to AA for the dogma, and seeing others as reponsible for changes in one's life-style.

Although lower levels of education and occupation are not necessarily associated with a helpless attributional style, that is, contributing detrimentally to the recovery process, these variables may however be seen as resources to enhance the recovery process. It would appear likely that a background involving more learning experiences in abstraction, or more learning experiences employing objective, problem-solving strategies, may tend to contribute to altering self-perceptions and ultimately, behavioral inclinations. This interpretation would appear to be consistent with the Cognitive Social Learning model (Marlatte & Donovan, 1982) which proposes that effective intervention should include acquiring new coping skills and developing higher levels of self-esteem through positive, self-efficacy-enhancement experiences.

Lack of experience with a negative life event may tend to minimize the potential enviornmental stressor leaving self-esteem level unchallenged and in-tact. Whether or not this variable is realistically related to a habitual style of seeing the self as responsible for the occurrence of good events, is not known because avoiding negative events such as loss of a loved one, cannot realistically be controlled by the individual.

Longer lengths of time in AA related to a tendency to accept credit for good events occurring, suggests that at least for some members, and in particular for women, AA tends to enhance this tendency, over time. This suggests that what may be occurring amongst the women, is a tendency to gain alleviation from isolation and alienation, alternatively acquiring a social-support system which tends to enhance the recovery process (Moos & Finney, 1983).

Higher levels of perceived improvement in one's life-style, relating to accepting credit for good events suggest that individuals making changes in their interactions with others in the

area of family life, and social and occupational spheres, are likely altering not only self-efficacy skills, but also self-efficacy beliefs about themselves. It would appear likely that positive self-changes are effecting positive changes from the environment, transactively or in other words, a reciprocal effect is occurring in which changed behavior is altering expectancies, which is altering attributions (Hollon & Garber,1980).

Heavy drinking levels of the fathers related to accepting the blame for bad events, appears to be consistent with Marlatte and Donovan's (1982) contention that early history factors of the individual may predispose that person to maladaptive expectations regarding alternative coping resources when challenged by perceived social stressors. That is, parental modeling of alcohol use relates to an individuals repetoire of coping strategies.

The relationship between depression experienced after joining AA and a tendency to generalize beyond a specific bad event, appears to be consistent with the Reformulated model of Learned Helplessness (Peterson & Seligman, 1984). This suggests that these individuals may be vulnerable to potential relapse danger that Marlatte (1979) proposes which incorporates guilt and lowered levels of self-esteem, should drinking be selected as an alternative response to a threatening, negative, life event.

The relationship between self-blame and attraction to AA for dogma, suggests that those persons who perceive the structure suggested by the Twelve Steps, as high priority in their lives, will also tend to blame the self when bad events occur. Contrasted to this were those who preferred other people in AA and who correspondingly were less inclined to blame the self when bad events occurred. This contrast appears to suggest that there are people in AA who need defined rules to live by and other people who need other people to learn various ways to cope with the on-going challenges of life. The former sub-group however, appears to be more vulnerable to helplessness when negative life situations occur.

Similarly, the association between perceived responsibility for changes in one's life as defined as being caused by others and accepting self-blame tendency suggests that those who do not believe that they are responsible for current changes in their lives, are more inclined to

accept the blame for bad event occurrences. In turn, inclination to accept self-blame for negative events, is associated, correspondingly, with lowered levels of self esteem and may serve to deter self-growth and contribute to potential relapse danger that Marlatte (1979) proposes. Additionally, this would also appear to be consistent with McGovern's (1983) contention that expectancies delineate choice and the production of responsible behavior. That is, the more a person sees himself as responsible for changes, the more he will be inclined to initiate further changes to increase alternatives or choices in his life, avoiding the danger of potential relapse.

Overall the results of this study appear to be in concordance with proponents of the multiple determinant approach to understanding alcohol abuse (Kissin & Hanson, 1982; Moos & Finney, 1983; Wanberg & Horn, 1983). Perhaps individualized assessment procedures may tend to produce more efficient and effective treatment programs, than those treatment programs currently available in Alberta.

B. Limitations

One of the major limitations in this study was the small sample of recovering alcohol abusers, recruited through Alcoholics Anonymous. In conducting research amongst AA members, the investigator was constrained by the principal of anonymity which was rigidly adhered to by many AA members, and which was respected by the investigator. In addition the Attributional Style Questionnaire (ASQ) may not adequately tap attributions of realistic importance to a recovering alcohol abusing population. It is suggested that measures of self-concept may be more relevant to these people during the recovery period. A second problem was in the design of the Personal Data Questionnaire, which lacked discriminate levels of comparison within the variable assessing negative life events and the variable assessing experienced depression, prior to problem drinking.

C. Directions for Further Research

Research should be undertaken in other substance abuse treatment facilities, comparing ASQ scores of different substance abusers. The ASQ should also be used in conjunction with a battery of complimentary tests assessing indices of self-esteem, social support, recent life stressors, negative life events and depression levels experienced. As well, ASQ should be employed and compared with pretreatment and post-treatment measures. Freed from economic and time constraints, a long-term study should be conducted on recovering alcohol abusers employing the ASQ and additional complimentary measures to evaluate recovery process over time. Alternatively, intensive single-case studies could also serve to evaluate the recovery process over time.

Since alcohol abuse is an area of current concern due to increases in alcohol-related social problems, and psycho-biological pathologies, Government should fund further research in this complex and challenging field.

VII. REFERENCES

Abramson, L.Y., Seligman, M.E.P., & Teasdale, J. (1978). Learned helplessness in humans: Critique and reformulation, *Journal of Abnormal Pyschology, 87*, 49-74.

Alcoholics Anonymous (1975). *Alcoholics Anonymous*. New York: AA World Services Incorporated.

Alcoholics Anonymous (1975). *Living Sober*. New York: AA World Services Incorporated.

Alcoholics Anonymous (1953). *Twelve Steps and Twelve Traditions*. New York: AA World Services Incorporated.

Alford, G.S. (1980). AA: An empirical outcome study. *Addictive Behaviors, 5*, 359-370.

Alibrandini, L.A. (1982). The fellowship of Alcoholics Anonymous. In E.M. Pattison & E. Kaufman (Eds.), *Encyclopedia Handbook of Alcoholism*. New York: Gardner Press.

Beck, A.T., Steer, R.A., & Shaw, B.F. (1984). Hopelessness in Alcohol and Heroin Dependent Women. *Journal of Clinical Psychology, 40*, 602-606.

Beckman, L.G. (1980). An attributional analysis of Alcoholics Anonymous. *Journal of Studies on Alcohol, 41*, 714-726.

Blum, K., Biggs, A., & Verebey, K. (1982). The pharmacology of addictive drugs: A review of similarities and differences. In J. Solomon and K.A. Kerley (Eds.), *Perspectives in Alcohol and Drug Abuse*. Littleton, MA: John Wright.

Burt, D.W. (1975). A behaviorist looks at AA. *Addictions, 22*, 56-69.

Carroll, J.F.X. (1982). Personality and Psychopathology: A comparison of alcoholic and drug-dependent persons. In J. Solomon and K.A. Kerley (Eds.), *Perspectives in Alcohol and Drug Abuse*. Littleton, MA: John Wright.

Davison, G.C., & Neale, J.M. (1978). *Abnormal Psychology*. New York: Wiley.

Digman, C. (1982). *Alcohol Use in Alberta: Costs and Consequences*. Edmonton: AADAC.

Donovan, D.M., & Marlatte, G.A. (1980). Behavioral Assessment of social and problematic drinking: A cognitive social learning formulation. *Journal of Studies on Alcohol, 41*, 1153-1185.

Emery, G. & Fox, S. (1981). Cognitive Therapy of alcohol dependency. In G. Emery, S.D. Hollon, & R.C. Bedrosen (Eds.), *New Directions In Cognitive Therapy*. New York: Guilford press.

Gellman, I.P. (1964). *The Sober Alcoholic: An Organizational Analysis of Alcoholics Anonymous*. New Haven, CT: College & University Press.

Gomberg, E.S.L. (1982). Women with alcohol problems. In N.J. Estes and M.E. Heinemann (Eds.), *Alcoholism : Development, Consequences and Interventions*. St. Louis: Mosby.

Goodwin, D.W. (1973). Alcohol problems in adoptees raised apart from alcoholic biological parents. *Archives of General Psychiatry, 28*, 238-243.

Goodwin, D.W., Schulsinger, F., Knop, J., Mednick, S., & Guze, S.B. (1977). Psychopathology in adopted and non-adopted daughters of alcoholics. *Archives of General Psychiatry, 34*, 1005-1009.

Harvey, J.H. & Galvin, K.S. (1984). Clinical implications of attribution theory and research. *Clinical Psychology Review, 4*, 15-33.

Heather, N., & Robertson, D. (1981). *Controlled Drinking*. London: Methuen.

Hennecke, L., & Fox, V. (1980). The woman with alcoholism. In S.E. Gitlow and H.S. Peyser (Eds.), *Alcoholism: A Practical Treatment Guide*. New York: Grune & Stratton.

Hoffman, N.G., Harrison, P.A., & Belille, C.A. (1983). Alcoholics Anonymous after treatment: Attendance and abstinence. *The International Journal of the Addictions, 18*, 311-318.

Hollon, S.D., & Garber, J. (1980). A cognitive-expectancy theory of therapy for helplessness and depression. In J. Garber & M.E.P. Seligman (Eds.), *Human Helplessness*. New York: Academic Press.

Hollon, S.D., & Kriss, M.R. (1984). Cognitive factors in clinical research and practice. *Clinical Psychology Review, 4*, 35-76.

Johnson, P.B. (1982). Sex differences, women's roles and alcohol use: Preliminary national data. *Journal of Social Issues, 38*, 93-116.

Kerlinger, F.N. (1973). *Foundations of Behavioral Research*. New York: Holt, Rinehart, and Winston, Incorporated.

Khantzian, E.J. (1982). Psychopathology, psychodynamics, and alcoholism. In E.M. Pattison and E. Kaufman (Eds.), *Encyclopedia Handbook of Alcoholism*. New York: Gardner Press.

Kinney, J. & Leaton, G. (1982). *Understanding Alcohol*. New York: C.V. Mosby Company.

Kissin, B., & Hanson, M. (1982). The Bio-pyscho-social perspective in alcoholism. In J. Solomon (Ed.), *Alcoholism and Clinical Psychiatry*. New York: Plenum.

Kurtines, W.M., Ball, L.R., & Wood, G.H. (1978). Personality characteristics of long term recovered alcoholics. *Journal of Consulting and Clinical Psychology, 46*, 971-977.

Kurtz, E. (1982). Why AA works. *Journal of Studies on Alcohol, 43*, 38-80.

Marlatte, G.A. (1979). Alcohol use and problem drinking: A cognitive-behavioral analysis. In P.C. Kendall and S.D. Hollon (Eds.), *Cognitive - Behavioral Interventions*. New York: Academic Press.

Marlatte, G.A., & Donovan, D.M. (1982). Behavioral psychology approaches to alcoholism. In E.M. Pattison and E. Kaufman (Eds.), *Encyclopedia Handbook of Alcoholism*. New York: Gardener Press.

Marsh, J.C. (1982). Public issues and private problems: Women and drug use. *Journal of Social Issues, 38*, 153-165.

McGovern, M.P. (1983). Comparative evaluation of medical vs social treatment of alcohol withdrawal syndrome. *Journal of Clinical Psychology, 39*, 791-803.

Miller, P.M. (1978). Behavior modification and Alcoholics Anonymous: An unlikely combination. *Behavior Therapy, 9*, 300-301.

Miller, W.R. & Hester, R.K. (1983). Treating the problem drinker: Modern Approaches. In W.R. Miller (Ed.), *The Addictive Behaviors*. New York: Pergamon Press.

Moos, R.H., & Finney, J.W. (1983). The expanding scope of alcoholism treatment evaluation. *American Psychologist, 38*, 1039-1044.

O'Brien, R., & Chafetz, M. (1982). *The Encyclopedia of Alcoholism*. New York: Facts On File Pub.

Pattison, E.M. (1979). The selection of treatment modalities for the alcoholic patient. In J.H. Mendleson & N.K. Mello (Eds.), *The Diagnosis and Treatment of Alcoholism*. New York: McGraw-Hill Book Company.

Peterson, C., & Seligman, M.E.P. (1984). Causal explanations as a risk factor for depression: Theory and evidence. *Psychological Review, 91*, 347-374.

Peterson, C., Semmel, A., von Baeyer, C., Abramson, L.Y., Metalsky, G.I., & Seligman, M.E.P. (1982). The Attributional Style Questionnaire. *Cognitive Therapy and Research, 6*, 284-300.

Saunders, B. (1980). Psychological aspects of women and alcohol. In Camberwell Council on Alcoholism (Ed.), *Women and Alcohol*. London: Tavistock.

Schuckitt, M.A., & Haglund, R.M.J. (1982). Etiological theories on alcoholism. In N.J. Estes and M.E. Heinemann (Eds.), *Alcoholism: Development, Consequences and Interventions*. St. Louis: Mosby.

Seligman, M.E.P. (1975). *Helplessness*. San Francisco: W. H. Freeman & Co.

Tucker, M.B. (1982). Social support and coping: Applications for the study of female drug abuse. *Journal of Social Issues, 38*, 117-137.

Wanberg, K.W., & Horn, J.L. (1983). Assessment of alcohol use with multidimensional concepts and measures. *American Psychologist, 38*, 1055-1069.

Westermeyer, J. (1976). *A Primer on Chemical Dependency*. Baltimore: Waverly Press.

Zucker, R.A. (1976). Parental influences on the drinking patterns of their children. In M. Greenblatt & M.A. Schuckit (Eds.), *Alcoholism Problems In Women And Children*. New York: Grune & Stratton Incorporated.

VIII. APPENDIX A

PERSONAL DATA QUESTIONNAIRE

I. D. # ____

PLEASE MAKE ONE RESPONSE (X) TO EACH OF THE FOLLOWING QUESTIONS:

1. What is your sex?

   Male _____

   Female _____

2. What is your marital status?

   Married _____

   Widowed _____

   Divorced _____

   Single _____

3. Please indicate number of older brothers and/or sisters _____

   Please indicate number of younger brothers and/or sisters _____

4. Where did you grow up?

   Large city _____

   Small city _____

   Village or town _____

   Farm _____

5. What age range best describes you?

   51 years and over _____

   46 - 50 years _____

   41 - 45 years _____

   36 - 40 years _____

   31 - 35 years _____

   26 - 30 years _____

   21 - 25 years _____

20 years and younger _____

6. Which level of education best describes you?

College and/or university _____

Grade 12 plus technical training _____

Grade 9 to grade 12 _____

Up to grade 8 _____

7. Which broad catagory of careers best describes your line of work?

Professional _____

Technical _____

Tradesperson _____

Services (i.e.: restaurant, sales, etc.) _____

Office work and/or clerical _____

Homemaker and/or retired _____

8. What time range best describes how long you have been with A.A.?

7 years and over _____

3 - 6 years _____

1 - 2 years _____

3 months to 11 months _____

2 months and under _____

9. How old were you when you had your first drink?

26 years and over _____

21 - 25 years _____

17 - 20 years _____

11 - 16 years _____

10 years and under _____

10. Who introduced you to drinking?

Parents _____

Friends _____

Self _____

11. In your opinion, your father drank alcohol

Not at all _____

Very little _____

Moderately _____

Heavily _____

12. In your opinion, your mother drank alcohol

Not at all _____

Very little _____

Moderately _____

Heavily _____

13. Did any of your brothers and/or sisters have problems with alcohol?

No _____

Yes _____

14. Did anyone in your family drink to:

Have fun _____

Feel better with others _____

Control angry feelings _____

Stop feeling anxious or fearful _____

Handle stressful situations _____

Stop feeling sad, blue, or depressed _____

More than one reason _____

15. In your opinion, did your parent(s) provide you with good examples of how to solve problems in life and/or how to get along with other people in life?

Yes, many times _____

Sometimes _____

Hardly ever _____

Not at all _____

16. What was your primary reason for drinking?

To have fun _____

To feel beter with others _____

To control angry feelings _____

To stop feeling anxious or fearful _____

To handle stressful situations _____

To stop feeling sad, blue, or depressed _____

More than one reason _____

17. In your early days of drinking, did you feel that you drank:

Differently from others who drank alcohol _____

Just the same as others who drank alcohol _____

18. In your latter days of drinking, did you feel that:

Alcohol was your major problem _____

Alcohol was just part of many problems _____

You just didn't know what was wrong in your life _____

19. Did you try to stop drinking on your own before you came to AA?

Yes _____

No _____

20. Did you seek assistance from any agency outside AA, such as AADAC?

Yes _____

No _____

21. What has attracted you most to AA?

I was really impressed by one particular person _____

I really liked the people in AA _____

I really liked what the Twelve Steps have to say _____

22. Before your experienced problems with alcohol, did you lose someone you loved and/or suffer a job loss?

    No _____

    Yes _____

23. Since you joined AA, have you experienced lossing someone you loved, and/or suffered a job loss?

    No _____

    Yes _____

24. Before drinking became a problem, did you experience feeling sad, blue or depressed for a week or more at a time?

    No _____

    Yes _____

25. Since you have joined AA, have you experienced feeling sad, blue or depressed for a week or more at a time?

    No _____

    Yes _____

26. Since your first meeting in AA, how much do you feel you have improved, personally?

    A great deal _____

    Somewhat _____

    Very little _____

    Not at all _____

27. How much do you think your work situation has improved, since joining AA?

    A great deal _____

    Somewhat _____

    Very little _____

    Not at all _____

28. How much do you think you family or home life has improved since joining AA?

A great deal _____

Somewhat _____

Very little _____

Not at all _____

29. In your opinion, are you doing more things in life now that you really enjoy?

A great deal _____

Somewhat _____

Very little _____

Not at all _____

30. Since you joined AA, who, in your opinion, is most responsible for the changes going on in your life?

Myself _____

Myself and others _____

Others _____

IX. APPENDIX B

ATTRIBUTIONAL STYLE QUESTIONNAIRE

DIRECTIONS

1. Read each situation and vividly imagine it happening to you.
2. Decide what you believe would be the major cause of the situation if it happened to you.
3. Write this cause in the blank provided.
4. Answer three questions about the cause.
5. Go on to the next situation.

SITUATIONS

1. YOU MEET A FRIEND WHO COMPLIMENTS YOU ON YOUR APPEARANCE.

   Write down the one major cause. _____

   a. Is the cause of your friend's compliment due to something about you or something about other people or circumstances?

      Totally due to other people or circumstances 1 2 3 4 5 6 7 Totally due to me

   b. In the future when you are with your friend, will this cause again be present?

      Will never again be present 1 2 3 4 5 6 7 Will always be present

   c. Is the cause something that just affects interacting with friends or does it also influence other areas of your life?

      Influences just this particular situation 1 2 3 4 5 6 7 Influences all situations in my life

2. YOU HAVE BEEN LOOKING FOR A JOB UNSUCCESSFULLY FOR SOME TIME

   Write down the one major cause. _____

   a. Is the cause of your unsuccessful job search due to something about you or something about other people or circumstances?

      Totally due to other Totally

people or circumstances 1 2 3 4 5 6 7 due to me

b. In the future when looking for a job, will this cause again be present?

Will never again Will always

bepresent 1 2 3 4 5 6 7 be present

c. Is the cause something that just influences looking for a job or does it also influence other areas of your life?

Influences just this Influences all

particular situation 1 2 3 4 5 6 7 situationsin my life

3. YOU BECOME VERY RICH

Write down the one major cause. _____

a. Is the cause of your becoming rich due to something about you or something about other people or circumstances?

Totally dueto other Totally due

people or circumstances 1 2 3 4 5 6 7 to me

b. In your financial future, will this cause again be present?

Will never again Will always

be present 1 2 3 4 5 6 7 be present

c. Is the cause something that just affects obtaining money or does it also influence other areas of your life?

Influences just this Influences all

particular situation 1 2 3 4 5 6 7 situationsin my life

4. A FRIEND COMES TO YOU WITH A PROBLEM AND YOU DON'T TRY TO HELP THEM.

Write down the one major cause. _____

a. Is the cause of your not helping your friend due to something about you or something about other people or circumstances?

Totally due to other Totally

people or circumstances 1 2 3 4 5 6 7 due to me

b. In the future when a friend comes to you with a problem, will this cause again be present?

Will never again Will always

be present 1 2 3 4 5 6 7 be present

c. Is the cause something that just affects what happens when a friend comes to you with a problem or does it also influence other areas of your life?

Influences just this Influences all

situation 1 2 3 4 5 6 7 situations in my life

5. YOU GIVE AN IMPORTANT TALK IN FRONT OF A GROUP AND THE AUDIENCE REACTS NEGATIVELY.

Write down the <u>one</u> major cause. _____

a. Is the cause of the audience reacting negatively due to something about you or something about other people or circumstances?

Totally due to other Totally due

people or circumstances 1 2 3 4 5 6 7 to me

b. In the future when giving talks, will this cause again be present?

Will never again Will always

be present 1 2 3 4 5 6 7 be present

c. Is the cause something that just influences giving talks or does it also influence other areas of your life?

Influences just this Influences all

particular situation 1 2 3 4 5 6 7 situations in my life

6. YOU DO A PROJECT WHICH IS HIGHLY PRAISED.

Write down the <u>one</u> major cause. _____

a. Is the cause of being praised due to something about you or something about other people or circumstances?

Totally due to other — Totally due

people or circumstances 1 2 3 4 5 6 7 — to me

b. In the future when doing a project, will this cause again be present?

Will never again — Will always

be present 1 2 3 4 5 6 7 — be present

c. Is the cause something that just affects doing projects or does it also influence other areas of your life?

Influences just this — Influences all

particular situation 1 2 3 4 5 6 7 — situations in my life

7. YOU MEET A FRIEND WHO ACTS HOSTILELY TOWARDS YOU.

Write down the <u>one</u> major cause. _____

a. Is the cause of your friend acting hostile due to something about you or something about other people or circumstances?

Totally due to other — Totally due

people or circumstances 1 2 3 4 5 6 7 — to me

b. In the future when interacting with friends, will this cause again be present?

Will never again — Will always

be present 1 2 3 4 5 6 7 — be present

c. Is the cause something that just influences interacting with friends or does it also influence other areas of your life?

Influences just this — Influences all

particular situation 1 2 3 4 5 6 7 — situations in my life

8. YOU CAN'T GET ALL THE WORK DONE THAT OTHERS EXPECT OF YOU.

Write down the <u>one</u> major cause. _____

a. Is the cause of you not getting the work done due to something about you or something about other people or circumstances?

Totally due to other — Totally due

people or circumstances 1 2 3 4 5 6 7 to me

b. In the future when doing work that others expect, will this cause again be present?

Will never again Will always

be present 1 2 3 4 5 6 7 be present

c. Is the cause something that just affects doing work that others expect of you or does it also influence other areas of your life?

Influences just this Influences all

particular situation 1 2 3 4 5 6 7 situations in my life

9. YOUR SPOUSE (BOYFRIEND/GIRLFRIEND) HAS BEEN TREATING YOU MORE LOVINGLY.

Write down the one major cause. _____

a. Is the cause of your spouse (boyfriend/girlfriend) treating you more lovingly due to something about you or something about other people or circumstances?

Totally due to other Totally due

people or circumstances 1 2 3 4 5 6 7 to me

b. In the future, interactions with your spouse (boyfriend/girlfriend), will this cause again be present?

Will never again Will always

be present 1 2 3 4 5 6 7 be present

c. Is this cause something that just affects how your spouse (boyfriend/girlfriend) treats you or does it also influence other areas of your life?

Influences just this Influences all

particular situation 1 2 3 4 5 6 7 situations in my life

10. YOU APPLY FOR A POSITION THAT YOU WANT VERY BADLY (e.g., IMPORTANT JOB, GRADUATE SCHOOL ADMISSION, etc.) AND YOU GET IT.

Write down the one major cause. _____

a. Is the cause of your getting the position due to something about you or something

about other people or circumstances?

Totally due to other — Totally due

people or circumstances 1 2 3 4 5 6 7 — to me

b. In the future when applying for a position, will this cause again be present?

Will never again — Will always

be present 1 2 3 4 5 6 7 — be present

c. Is the cause something that just influences applying for a position or does it also influence other areas of your life?

Influences just this — Influences all

particular situation 1 2 3 4 5 6 7 — situations in my life

11. YOU GO OUT ON A DATE AND IT GOES BADLY.

Write down the <u>one</u> major cause. _____

a. Is the cause of the date going badly due to something about you or something about other people or circumstances?

Totally due to other — Totally due

people or circumstances 1 2 3 4 5 6 7 — to me

b. In the future when dating, will this cause again be present?

Will never again — Will always

be present 1 2 3 4 5 6 7 — be present

c. Is the cause something that just influences dating or does it also influence other areas of your life?

Influences just this — Influences all

particular situation 1 2 3 4 5 6 7 — situations in my life

12. YOU GET A RAISE.

Write down the <u>one</u> major cause. _____

a. Is the cause of your getting a raise due to something about you or something about other people or circumstances?

Totally due to other people or circumstances 1 2 3 4 5 6 7 Totally due to me

b. In the future on your job, will this cause again be present?

Will never again be present 1 2 3 4 5 6 7 Will always be present

c. Is this cause something that just affects getting a raise or does it also influence other areas of your life?

Influences just this particular situation 1 2 3 4 5 6 7 Influences all situations in my life

X. APPENDIX C

ALCOHOLICS ANONYMOUS

Twelve Steps of Alcoholics Anonymous

1. We admitted we were powerless over alcohol - that our lives had become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God as we understood him.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked Him to remove our shortcomings.
8. Made a list of all persons we had harmed, and became willing to make amends to them all.
9. Made direct amends to such people whereever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong, promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these Steps, we tried to carry this message to alcoholics and to practice these principles in all our affairs.

The Twelve Traditions of Alcoholics Anonymous

1. Our common welfare should come first; personal recovery depends upon A.A. unity.
2. For our group purpose there is but one ultimate authority - a loving God as He may express Himself in our group conscience. Our leaders are but trusted servants; they do not govern.
3. The only requirement for A.A. membership is a desire to stop drinking.

4. Each group should autonomous except in matters affecting other groups or A.A. as a whole.
5. Each group has but one primary purpose - to carry its message to the alcoholic who still suffers.
6. An A.A. group ought never endorse, finance or lend the A.A. name to any related facility or outside enterprise, lest problems of money, property and prestige divert us from our primary purpose.
7. Every A.A. group ought to be fully self-supporting, declining outside contributions.
8. Alcoholics Anonymous should remain forever non- professional, but our service centers may employ special workers.
9. A.A., as such, ought never be organized; but we may create service boards or committees directly responsible to those they serve.
10. Alcoholics Anonymous has no opinion on outside issues; hence the A.A. name ought never be drawn into public controversy.
11. Our public relations policy is based on attraction rather than promotion; we need always maintain personal anonymity at the level of press, radio and films.
12. Anonymity is the spiritual foundation of all our Traditions, ever reminding us to place principles before personalities.